DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 0 2

2. STATE: NEBRASKA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR, SUBPART C

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 2,200,000
b. FFY 2003 $ 4,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATT. 4.19-D, Pages 1-30

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATT. 4.19-D, Pages 1-22

10. SUBJECT OF AMENDMENT:
REIMBURSEMENT OF NURSING FACILITIES

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
GOVERNOR HAS WAIVED REVIEW

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert J. Seiffert

13. TYPED NAME:
ROBERT J. SEIFFERT

14. TITLE:
MEDICAID ADMINISTRATOR

15. DATE SUBMITTED:
January 25, 2002

16. RETURN TO:
HHS, F&S
MEDICAID DIVISION
ATTN: MARGARET BOOTH
P.O. BOX 95026
LINCOLN, NE 69509-5026

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
01/28/02

18. DATE APPROVED:
APR 25 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
2/01/02

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid & State Operations

23. REMARKS:
cc:
Seiffert
Booth
CO
OSG/DIATA

SPA CONTROL
Date Submitted: 01/25/02
Date Received: 01/28/02 (Incomplete submission)
Date Received: 02/01/02 (Complete submission)

12-011 Rates for Nursing Facility Services

12-011.01 Purpose: This section -

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447.250 through 42 CFR 447.272;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and
4. Provides for public notice of changes in the statewide method or level of payment pursuant to the requirements of Section 1902(a)(13) of the Social Security Act.

The rate determination described herein is effective beginning January 1, 2002.

12-011.02 Definitions: The following definitions apply to the nursing facility rate determination system.

Allowable Cost: Those facility costs which are included in the computation of the facility's per diem. The facility's reported costs may be reduced because they are not allowable under Medicaid or Medicare regulation, or because they are limited under 471 NAC 12-011.06.

Assisted Living Rates: Standard rates, single occupancy, rural or urban, per day equivalent, paid under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

Interim Year Maximum: The base year maximum increased by the applicable inflation factor.

Level of Care: The classification (see 471 NAC 12-013.01) of each resident based on his/her acuity level.

Median: A value or an average of two values in an ordered set of values, below and above which there is an equal number of values.

Nursing Facility: An institution (or a distinct part of an institution) which meets the definition and requirements of Title XIX of the Social Security Act, Section 1919.

Rate Determination: Per diem rates calculated under provisions of 471 NAC 12-011.08. These rates may differ from rates actually paid for nursing facility services for Levels of Care 35 and 36.

Rate Payment: Per diem rates paid under provisions of 471 NAC 12-011.08. The payment rate for Levels of Care 35 and 36 shall be the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

Urban: Urban area counties defined as Metropolitan Statistical Areas by the United States Office of Management and Budget.

Waivered Facility: Facilities for which the State Certification Agency has waived professional nurse staffing requirements of OBRA 87 are classified as "waivered" if the total number of waivered days exceeds 90 calendar days at any time during the reporting period.

Weighted Resident Days: A facility's inpatient days, as adjusted for the acuity level of the residents in that facility (see 471 NAC 12-013.03 and 12-013.04).

Other definitions which apply in this section are included in Nebraska Department of Health and Human Services Regulation and Licensure's Regulations in Title 175, Chapter 12, Skilled Nursing Facilities, Nursing Facilities and Intermediate Care Facilities and appropriate federal regulations governing Title XIX and Title XVIII.

12-011.03 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as of July 1, 2000 are used in determining the cost for Nebraska nursing facilities with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (NMAP) except as limited in this section. The aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities.

A provider with 1,000 or fewer Medicaid inpatient days during a Report Period (see 471 NAC 12-011.08B) will not file a cost report. When no cost report is filed for a Rebase Year, the rate paid will be determined as the sum of the maximums for the Direct Nursing Component, the Direct Support Services Component, and the Other Support Services Component, and the median for the Fixed Cost Component (see 471 NAC 12-011.08D1, D2, D3, and D4) for the facility's respective Care Classification (see 471 NAC 12-011.08C), plus the Inflation Factor (see 471 NAC 12-011.08D5). The rate paid for the Interim Years will be the Rebase Year rate adjusted by the respective Inflation Factor.

12-011.04 Allowable Costs: The following items are allowable costs under NMAP.

12-011.04A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to -

1. Meet the definition and requirements for a Nursing Facility of Title XIX of the Social Security Act, Section 1919;
2. Comply with the standards prescribed by the Secretary of Health and Human Services (HHS) for nursing facilities or centers for the developmentally disabled in 42 CFR 442;
3. Comply with requirements established by the Nebraska Health and Human Services Regulation and Licensure, the state agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing nursing facility or developmental disability center services, as applicable.

12-011.04B Routine Services: Routine nursing facility services include regular room, dietary, and nursing services; social services where required by certification standards; minor medical supplies; oxygen; the use of equipment and facilities; and other routine services. Examples of items that routine services may include are -

1. All general nursing services, including administration of oxygen and related medications; collection of all laboratory specimens as ordered by the physician, such as: blood, urine; handfeeding; incontinency care; tray service; normal personal hygiene which includes bathing, skin care, hair care (excluding professional barber and beauty services), nail care, shaving, and oral hygiene; enema; etc.;
2. Maintenance Therapy: facility staff shall aid the resident as necessary, under the resident's therapy program, with programs intended to maintain the function(s) being restored;

3. Items which are furnished routinely and relatively uniformly to all patients, such as patient gowns, water pitchers, basins, bedpans, etc.;
4. Items stocked at nursing stations or on each floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, bandaids, incontinency care products, colostomy supplies, catheters, irrigation equipment, tape, needles, syringes, I.V. equipment, T.E.D. (anti-embolism) stockings, hydrogen peroxide, O-T-C enemas, tests (Clinitest, Testape, Ketostix), tongue depressors, hearing aid batteries, facial tissue, personal hygiene items (which includes soap, lotion, powder, shampoo, deodorant, tooth-brushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, etc.), etc.;
5. Items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, gerichairs, traction equipment, alternating pressure pad and pump, other durable medical equipment, etc.;
6. Special dietary supplements used for tube feeding or oral feeding, such as an elemental high nitrogen diet, even if written as a prescription item by a physician. These supplements have been classified by the Food and Drug Administration as a food rather than a drug;
7. Laundry services, including personal clothing; and
8. Cost of providing basic cable television service, including applicable installation charge, to individual rooms. This is not a mandatory service.

12-011.04C Ancillary Services: Ancillary services are those services which are either provided by or purchased by a facility and are not properly classified as "routine services." The facility shall contract for ancillary services not readily available in the facility.

If ancillary services are provided by a licensed provider or another licensed facility, e.g., physician, dentist, etc., the provider shall submit a separate claim for each client served.

Respiratory therapy is an allowable cost.

Department-required independent QMRP assessments are considered ancillary services.

12-011.04D Payments to Other Providers: Items for which payment may be authorized to non-Nursing Facility or ICF/MR providers and are not considered part of the facility's Medicaid per diem are listed below. To be covered, the client's condition must meet the criteria for coverage for the item as outlined in the appropriate Medicaid provider chapter. The provider of the service may be required to request prior authorization of payment for the service.

1. Legend drugs, OTC drugs, and compounded prescriptions, including intravenous solutions and dilutants (see 471 NAC 16-000);
2. Personal appliances and devices, if recommended in writing by a physician, such as eye glasses, hearing aids, etc.;
3. Wheelchairs are considered necessary equipment in a nursing facility to provide care. Non-standard wheelchairs, including power-operated vehicles, and wheelchair seating systems, including certain pressure reducing wheelchair cushions, needed for the client's permanent and full time use may be approved (see 471 NAC 7-000);
4. Air fluidized bed units and low air loss bed units (see 471 NAC 7-000);
5. Augmentative communication devices/accessories (see 471 NAC 7-000);
6. Supports (elastic stockings, trusses, etc.) as defined in 471 NAC 7-000 excluding surgical/anti-embolism stockings;
7. Orthoses (lower and upper limb, foot and spinal) as defined in 471 NAC 7-000;
8. Prostheses (breast, eye, lower and upper limb) as defined in 471 NAC 7-000;
9. Oxygen and oxygen equipment, if the client's prescribed need for oxygen meets the minimum liters per minute (LPM) and hours per day as outlined below:

LPM	Minimum Hours Per Day
1.5	24
2	14
2.5	12
3	10
3.5	9
4	8
4.5	7
5	6

10. Repair of medically necessary, client-owned durable medical equipment otherwise covered for clients residing in Nursing Facilities and ICF/MR's;
11. Parenteral nutrition solution and additives;
12. Ambulance services required to transport a client to obtain and after receiving Medicaid-covered medical care which meet the definitions in 471 NAC 4-000.
    a. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the client's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the client's health, whether or not such other transportation is actually available, NMAP shall not make payment for ambulance service.

b. Non-emergency ambulance transports to a physician/practitioner's office, clinic, or therapy center are covered when the client is bed confined before, during and after transport AND when the services cannot or cannot reasonable be expected to be provided at the client's residence (including the Nursing Facility and/or ICF/MR).

12-011.05 Unallowable Costs: The following costs are specifically unallowable:

1. Provisions for income tax;
2. Fees paid board of directors;
3. Non-working officers' salaries;
4. Promotion expenses, except for promotion and advertising as allowed in HIM-15. Yellow Page display advertising is not allowable; one Yellow Page informational listing per local area telephone directory is allowable;
5. Travel and entertainment, other than for professional meetings and direct operations of facility. This may include costs of motor homes, boats, and other recreational vehicles, including operation and maintenance expenses; real property used as vacation facilities; etc.;
6. Donations;
7. Expenses of non-nursing home facilities and operations included in expenses;
8. Insurance and/or annuity premiums on the life of the officer or owner;
9. Bad debts, charity, and courtesy allowances;
10. Costs and portions of costs which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular expenditure;
11. Services provided by the clients' physicians or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state operated facilities. These exclusions are paid separately;
12. Return on equity;
13. Carry-over of costs "lost" due to any limitation in this system; and
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients which are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, handball courts.

12-011.06 Limitations for Rate Determination: The Department applies the following limitations for rate determination.

12-011.06A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.

12-011.06B Total Inpatient Days: In computing the provider's allowable per diem rates, total inpatient days are the greater of the actual occupancy or eighty-five (85) percent of total licensed and certified bed days. For new construction (entire facility or bed additions) or a facility reopening, total inpatient days are the greater of the actual occupancy or fifty (50) percent of total licensed and certified bed days available during the first year of operation, beginning with the first day patients are admitted for care.

An inpatient day is:

1. A day on which a patient occupies a bed at midnight. When a client is admitted to a facility and dies before midnight on the same day, one day is counted and paid; or
2. A day on which the bed is held for hospital leave or therapeutic home visits.

Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for fifteen (15) days per hospitalization and for up to eighteen (18) days of therapeutic home visits per calendar year.

Medicaid inpatient days are days for which claims (Printout MC-4, "Long Term Care Facility Turnaround Billing Document") from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a "spenddown" category are considered Medicaid inpatient days in compiling inpatient days. A facility may not impose charges that exceed the payment rate established under 471 NAC 12-011 ff. for these days.

12-011.06C Start-Up Costs: All new providers entering NMAP shall capitalize and amortize their allowable start-up costs. Only those costs incurred three months before the admission of the first client (private or Medicaid) may be capitalized and amortized. These costs must be documented and submitted with the provider's initial cost report. Amortization of these costs begins on the date of the first admission and must extend over at least 36 months, but must not exceed 60 months.

Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

12-011.06D Common Ownership or Control: Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that -

1. The supplying organization is a bona fide separate organization;
2. A substantial part of the supplying organization's business activity is transacted with other than the provider and organizations related to the supplier by common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
3. The services, facilities, or supplies are those which commonly are obtained by institutions like the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by similar institutions; and
4. The charge to the provider is in line with the charge for those services, facilities, or supplies in the open market, and is no more than the charges made under comparable circumstances to others by the organization for those services, facilities, or supplies.

When all conditions of this exception are met, the charges by the supplier to the provider for services, facilities, or supplies are allowable as costs.

12-011.06E Leased Facilities: Allowable costs for leased facilities (including, but not limited to, leases, subleases, and other similar types of contractual arrangements), including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation, interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of 471 NAC 12-011.06H and J will apply, except that the Department does not recapture depreciation on leases between unrelated parties. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will -

1. Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and
2. Make records available for audit upon request of the Department, the Department of Health and Human Services (HHS), or their designated representatives.

12-011.06F Home Office Costs - Chain Operations: A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care.

Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicaid program is that of a related organization to participating providers. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the cost report. Costs allocated under HIM-15, Section 2150.3.B, shall be limited to direct, patient care services provided at the facility, and shall be included in the applicable Cost Category. Costs allocated under HIM-15, Sections 2150.3C and 2150.3D, shall be included in the Administration Cost Category. The NMAP does not distinguish between capital related and non-capital related interest expense and interest income (see HIM-15, Section 2150.3E and 2150.3F).

12-011.06G Interest Expense: Interest cost will not be allowed on loan principal balances which are in excess of 80 percent of the fixed asset cost recognized by the Department for long term care. This limitation does not apply to government owned facilities.

12-011.06H Recognition of Fixed Cost Basis: The fixed cost basis for facilities purchased as an ongoing operation or for newly constructed facilities or facility additions shall be the lesser of -

1. The acquisition cost of the asset to the new owner;
2. The acquisition cost which is approved by the Nebraska Health and Human Services Regulation and Licensure Certificate of Need process; or
3. For facilities purchased as an ongoing operation on or after December 1, 1984, the allowable cost of the asset to the owner of record as of December 1, 1984, or for assets not in existence as of December 1, 1984, the first owner of record thereafter.

471 NAC 12-011.08D, Recapture of Depreciation, will apply to this part.

Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made are not allowable.

This part will not apply to changes of ownership of assets pursuant to an enforceable agreement entered into before December 1, 1984.

12-011.06J Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 12-011, et seq., the fixed costs reported to the Health and Human Services Finance and Support for a Health and Human Services Regulation and Licensure Certificate of Need reviewed project shall not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

Certificate of Need provisions recognized by the Health and Human Services Finance and Support, for the purposes of rate setting, shall be the original project as approved, the approved project amendments submitted within 90 days of the transfer of ownership or opening of newly constructed areas, and the allowable cost overruns disclosed in a final project report submitted to the Health and Human Services Regulation and Licensure within 180 days of the opening of newly constructed areas. Project amendments and project reports submitted to the Health and Human Services Regulation and Licensure Certificate of Need after the periods defined above will be recognized upon approval beginning on the date that the amendment or report is received by the Health and Human Services Regulation and Licensure Division of Hospital and Medical Care Facilities. The added costs incurred prior to the date the late amendment or report is filed will not be recognized retroactively for rate setting.

12-011.06K Salaries of Administrators, Owners, and Directly Related Parties: Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the Department of Health and Human Services. All compensation received by an Administrator is included in the Administration Cost Category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Nebraska Department of Personnel in the "State of Nebraska Salary Survey".

12-011.06L Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable Direct Nursing, Direct Support Services, and Other Support Services Components for the facility.

This computation is made by dividing the total allowable Direct Nursing, Direct Support Services, and Other Support Services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Direct Nursing, Direct Support Services, and Other Support Services components, including the administration cost category. If a facility's actual allowable cost for the three components exceeds this quotient, the excess amount is used to adjust the administration cost category.

12-011.06M Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

12-011.07 Contracting Determination: Prior to January 1, 2001, facilities could elect to contract with the Department for payment for nursing facility services. Effective January 1, 2001, all facilities that are contracting with the Department shall transition, as their contracting term expires, to rate determination per 471 NAC 12-011.08. The Department determines rates for this methodology under the following guidelines with the provisions of 471 NAC 12-011.07B3 implemented effective January 1, 2002.

12-011.07A General Contracting Provisions:

12-011.07A1 Effective Dates: Beginning August 1, 1998, any facility may request to contract with the Department. A contract may only go into effect on the first day of a month. A contract rate period begins the first day of the month following approval by the Department for a facility to contract, and is in effect for the following twelve months. If it is mandatory that a facility contract, the first contract rate period must begin no later than the first day of the month following the date which a Medicaid eligible resident is admitted to an assisted living bed.

12-011.07A2 Time Periods Covered: The facility's contract with the Department covers services provided: 1) from July 1 through the last day of the month before contracting begins, 2) from the first day of the month that contracting begins through the following twelve months, and 3) for the following three one-year extensions.

12-011.07A3 Termination from Contracting Provision: Unless a facility has received grant money under the Nebraska Health Care Trust Fund for the conversion of beds, it may terminate its contract following forty-five days notice to the Department. When a facility terminates its contract, nursing facility payment rates will be calculated under provisions of 471 NAC 12-011.07A. The rates received under contracting will continue as the facility's interim rates. If a facility terminates its contract, it is not eligible to contract again for a period of four years; if a change of ownership occurs, the four year period is waived.

A facility which has received a grant from the Nebraska Health Care Trust Fund for the conversion of beds may not terminate contracting provisions.

12-011.07B Notification: The facility must notify the Department of its desire to contract. Notification shall be postmarked no later than 45 calendar days before the facility's desired first contract rate period.

12-011.07B1 Cost Reporting: A cost report must be maintained for the time period which is the basis for setting contracting rates (see 471 NAC 12-011.07B2a) and is subject to audit. A cost report is not required for the twelve-month extension periods; however, upon request by the Department, the facility must make available revenue and cost information from audited reports for governmental facilities, federal form 990 return for non-profit facilities, and federal tax returns for proprietary facilities.

12-011.07B2 Contract Rates: A nursing facility's case-mix payment rates are determined as follows:

12-011.07B2a Cost Report Used: Level of care rates are determined from the most current desk audited cost report. These are rates which would be effective for each prior June 30 cost report period.

12-011.07B2b The Time Period from July 1 to the Date that Contracting Begins: Retroactive rates for this time period are computed as follows when a facility elects to contract:

rates determined from the applicable cost report are projected forward from the midpoint of that cost report period to the midpoint of July 1 to the date contracting begins using the inflation factor. Adjustments are computed using 1/12 of the factor for each month. Interim rates paid during this period are retroactively adjusted to rates thus determined.

12-011.07B2c The Time Period from the Date that Contracting Begins to the End of the following Twelve Months (the First Contract Rate Period): Prospective rates for this time period are computed as follows:

rates determined from the cost report used are projected forward from the midpoint of that cost report period to the midpoint of the contract year using the inflation factor. Partial year adjustments are computed using 1/12 of the Factor for each month.

12-011.07B2d The Time Periods of the Next Three Twelve-Month Extensions: Prospective Rates for each 12 month extension are computed as follows:

rates from the first contract rate period are updated annually, effective the first day of each period, using the inflation factor.

12-011.07B2e Audit Adjustments: All contract rates may be adjusted based on a subsequent field audit of the cost report which forms the basis of setting rates (see 471 NAC 12-011.07B2a). Final determination of rates occurs when the field audit is finalized.

12-011.07B3 Phase-out of Contracting Provisions: The terms of all contracts existing as of January 1, 2002, will be modified. A contract may expire; a facility under a voluntary contract may notify the Department of its intent to terminate the contractual arrangement; a facility under mandatory contracting provisions may notify the Department of its intent to terminate the contractual arrangement; or any still existing contract will expire on December 31, 2003.

1. Contracts Expiring Four Years after Initiation: Facilities' rates will be updated through the end of the calendar year using the respective Inflation Factor. Facilities are required to submit a fiscal year cost report for June 30 of the year that the contract expires. The following calendar year's rates will be computed per provisions of 471 NAC 12-011.08, subject to Component maximums (see 471 NAC 12-011.08D1 through 471 NAC 12-011.08D3) as computed for those June 30 cost reports, plus the Inflation Factor (see 471 NAC 12-011.08D5) adjustment for that year.
2. Notification of Intent to Terminate: Facilities' rates will be updated through the end of that calendar year using the then current Inflation Factor. Facilities are required to submit a fiscal year cost report through June 30 of that year. The following calendar year's rates will be computed per provisions of 471 NAC 12-011.08, subject to Component maximums (see 471 NAC 12-011.08D1 through 471 NAC 12-011.08D3) as computed for those June 30 cost reports, and an Inflation Factor (see 471 NAC 12-011.08D5), as adjusted, for that year.
3. All Other Facilities Contracting as of December 31, 2003: Facilities are required to submit a fiscal year cost report through June 30, 2003. The following calendar year's rates will be computed per provisions of 471 NAC 12-011.08.
4. Facilities that are Contracting under Mandatory Requirements: A facility that has received grant money under the Nebraska Health Care Trust Fund for the conversion of nursing facility beds may, at its discretion, elect to terminate contracting provisions at the end of any calendar year prior to December 31, 2003. Rates shall be computed per provisions above for "Notification of Intent to Terminate". The Facility shall inform the Department via letter, submitted with its June 30 cost report, that it is electing to be reimbursed under provisions of 471 NAC 12-011.08 Rate Determination. The facility's decision then becomes final.

   In the event of conflict between this Section and Sections 12-011.07A through 12-011.07B2e, provisions of Section 12-011.07B3 shall govern.

12-011.08 Rate Determination: The rate determination provisions of 471 NAC 12-011.08 are in effect beginning January 1, 2001. The Department determines rates for facilities under the following cost-based prospective methodology –